



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RUSS BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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January 19, 2018

Josh Smith, Administrator
Oak Creek Rehabilitation Center of Kimberly
500 Polk Street East
Kimberly, ID 83341-1618

Provider #: 135084

Dear Mr. Smith:

On **January 12, 2018**, a survey was conducted at Oak Creek Rehabilitation Center of Kimberly by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 29, 2018**. Failure to submit an acceptable PoC by **January 29, 2018**, may result in the imposition of penalties by **February 23, 2018**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **February 16, 2018 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **April 12, 2018**. A change in the seriousness of the deficiencies on **February 26, 2018**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **April 12, 2018** includes the following:

Denial of payment for new admissions effective **April 12, 2018**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 11, 2018**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 12, 2018** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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Go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **January 29, 2018**. If your request for informal dispute resolution is received after **January 29, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in cursive script, appearing to read "Nina Sanderson LSW".

Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/01/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135084	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2018
NAME OF PROVIDER OR SUPPLIER OAK CREEK REHABILITATION CENTER OF KIMBERLY			STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
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F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint investigation survey conducted January 8, 2018 to January 12, 2018. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Teresa Kobza, RDN, LD ABBREVIATIONS: ADON = Assistant Director of Nursing CDM = Certified Dietary Manager CNA = Certified Nursing Assistant DON = Director of Nursing G-Tube = Gastrostomy Tube MDS = Minimum Data Set ml = milliliters mg = milligrams LPN = Licensed Practical Nurse	F 000			
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure residents' call lights were within reach and could be used when needed. This was true	F 558	1. One resident (#6) was impacted by the deficient practice. Resident's bed was moved to ensure that call light was consistently able to be within the	2/16/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/29/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 558	<p>Continued From page 1 for 1 of 12 (#6) sample residents reviewed for call light accessibility. This created the potential for harm if Resident #6 could not summon staff for assistance when needed. Findings include:</p> <p>Resident #6 was admitted to the facility on 11/1/10 with multiple diagnoses, including contractures and quadriplegia.</p> <p>The annual MDS assessment, dated 10/24/17, documented Resident #6 was severely cognitively impaired and dependent on staff for all care needs.</p> <p>The Room Change Care Plan, dated 12/5/17, documented Resident #6 utilized a call light to notify staff of his needs.</p> <p>On 1/8/18 from 4:00 PM to 4:22 PM, Resident #6 was observed lying in bed. Resident #6's bed was positioned against the wall, and there was an end table at the foot of his bed. Resident #6's call light was placed on top of the end table; which was approximately 6 feet from his reach. At 4:23 PM, CNA #6 and CNA #1 assisted Resident #6 with cares, and placed the call light within his reach before leaving the room.</p> <p>On 1/8/18 at 4:43 PM, Resident #6 activated his call light and it was answered by CNA #5.</p> <p>On 1/9/18 from 9:15 AM to 10:00 AM, Resident #6's call light was located approximately three feet from his reach. At 10:00 AM, CNA #7 entered Resident #6's room to offer him fluids. Before leaving Resident #6's room, CNA #7 located his call light, and discovered the cord could not extend to where he could access the</p>	F 558	<p>resident's reach.</p> <p>2. All residents within the facility have the potential to be impacted. All staff were in serviced on proper call light usage and placement.</p> <p>3. Ambassador rounds conducted by Department heads daily, Monday-Friday, excluding holidays, and PRN for rooms with identified deficiencies. Ambassador rounds sheets updated to document usage and placement of call lights. Ambassador rounds will be discussed during Stand up meetings.</p> <p>4. Facility Resident-in-room QAPI audit implements a call light function and placement as an audit item and will be brought to QAPI monthly x3. Audit conducted by Administrator or designee.</p> <p>5. 16 February 2018</p>		

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F 558	Continued From page 2 call light. CNA #7 moved Resident #6's bed closer to the wall where the call light was plugged in for accessibility. On 1/11/18 from 1:00 PM to 1:21 PM, Resident #6 was lying in bed with his call light located half-way down his stomach, and out of his reach. At 1:21 PM, the DON repositioned his call light and stated, "the call light was probably not in his reach." On 1/11/18 at 1:25 PM, the DON stated call lights were "used so residents could get help when they need it," and needed to be "accessible."	F 558			
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports	F 577		2/16/18	

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F 577	<p>Continued From page 3 in areas of the facility that are prominent and accessible to the public.</p> <p>(iv) The facility shall not make available identifying information about complainants or residents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and resident and staff interview, it was determined the facility failed to ensure complaint investigations for the 3 previous years were available for review. This deficient practice affected 5 of 5 residents in group and all other residents or their representative or visitors who may want to review the survey results. Findings include:</p> <p>On 1/9/18 at 1:15 PM, 5 of 5 residents in a group interview did not know where the survey results were located in the facility.</p> <p>On 01/10/18 at 2:00 PM, the survey results binder was observed at the main nurse's station. The binder contained the most recent recertification survey the facility had undergone on 9/23/16.</p> <p>During the same observation on 1/10/18 at 2:00 PM, in front of the survey binder, documented the last 3 years of surveys were available upon request. The survey binder did not include the complaint investigations on 4/13/17, 7/21/17, and 10/4/17.</p> <p>On 1/11/18 at 1:14 PM, the Administrator was informed of the lack of complaint investigations in 2017 were not available to review in the survey binder, and residents residing in the facility did not know where the survey binder was located.</p>	F 577	<ol style="list-style-type: none"> Five residents from the resident council group were impacted by the deficient practice. Survey binder was updated on 1/11/2018. All residents have the potential to be impacted. Education on location of survey binder provided to all residents. Resident council members will be educated on the location of the survey binder. An audit of the survey binder for completion and accuracy will be added as an item to the Facility Environment QAPI audit. Facility Environment QAPI audit is on the audit schedule with a frequency of monthly. Audit conducted by Administrator or designee. 16 February 2018 		

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F 658 SS=D	<p>Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 2 of 15 sampled residents (#15 and #22). Resident #15's medications were administered via G-tube without checking for tube placement prior to administration of medications or feedings, and medications were mixed and administered together. Resident #22's neurological assessment was not completed after an unwitnessed fall. These failed practices had the potential to adversely affect or harm residents whose cares were not delivered according to accepted standards of clinical practices. Findings include:</p> <p>Nursing Interventions and Clinical Skills (Elkin, Perry, Potter, 3rd Ed.) documented each medication should be individually dissolved in water and administered by syringe via gravity into a G-tube. The G-tube should be flushed with 10 ml of water before and after each medication.</p> <p>The facility's Administering Medications through an Enteral Tube policy and procedure, dated 1/1/16, included, "With gloves on, check for proper tube placement using air and auscultation only. Administer each medication separately and flush the tubing between each medication. Flush</p>	F 658	<p>1. Two residents (315 and #22) were impacted by the deficient practice. Resident #15 was impacted due to improper procedure being performed in regards to medication administration via G-tube. All nurses were given, and passed, a feeding tube competency check sheet which was done both during and after survey. Resident #22 was impacted in regards to incomplete neurological checks after an unwitnessed fall. LN staff in serviced on importance and procedure of conducting neurological checks.</p> <p>2. All residents that have a G-tube have the potential to be impacted by the deficient practice. All residents who sustain an unwitnessed fall have the potential to be impacted.</p> <p>3. Current G-tube policy will be revised to meet current standards and pharmacy will review current G-tube medication for the possibility and appropriateness of mixing medications per new guidelines. All neurological assessment sheets will be checked for accuracy and completion at the daily clinical meeting, 5 days a week,</p>	2/16/18	

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F 658	<p>Continued From page 5 tube with 15 ml of purified or sterile water between each medication."</p> <p>1. Resident #15 was admitted to the facility on 5/3/12 with multiple diagnoses, including dysphagia related to a stroke.</p> <p>Resident #15's Medication Review Report, dated 1/4/18, documented staff were to 1) check tube placement of peg tube via auscultation prior to medications, feedings, and water administration; and 2) flush peg tube with 30 ml water before and after each medication administration.</p> <p>On 1/10/18 at 12:00 PM, LPN #1 was not observed to check for G-tube placement for Resident #15 prior to medication administration.</p> <p>On 1/10/18 at 12:00 PM, LPN #1 stated she checked for tube placement on Resident 15's G-tube before and after feedings only.</p> <p>On 1/10/18 at 2:45 PM, LPN #1 was not observed to check Resident #15's G-tube placement prior to medication administration. LPN #1 was observed flushing Resident #15's G-tube with 60 ml water, administering Ativan 0.5 mg and Neurontin 100 mg together in 30 ml of water, and flushing the G-tube with 60 ml of water.</p> <p>On 1/10/18 at 2:45 PM, LPN #1 stated she mixed Resident #15's Ativan and Neurontin together because it was "okay" to do so.</p> <p>On 1/10/18 at 5:30 PM, LPN #1 was not observed to check for tube placement prior to tube feeding administration.</p>	F 658	<p>excluding holidays.</p> <p>4. G-tube feeding and medication administration audit tool developed. Audit will be conducted weekly x4 and then monthly x3 to ensure LN staff are performing this service to professional standard of quality. Audit will be conducted by DON or designee. Audits will be reviewed at each QAPI meeting for compliance.</p> <p>5. 16 February 2018</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 658	Continued From page 6 On 1/10/18 at 5:30 PM, LPN #1 stated, "I forgot to check for tube placement." On 1/11/18 at 1:45 PM, the DON stated the nurses should always check tube placement prior to administering medications, water flushes, and feedings. The DON stated medications should be administered separately, and never mix medications together. 2. Resident #22 was admitted to the facility on 8/28/15 with multiple diagnoses including Huntington's disease. An Incident and Accident Report, dated 1/1/18 at 1:28 AM, documented Resident #22 was found in her bedroom sitting on the floor mat with her back leaning against the side of the bed. A Neurological Assessment was initiated at 1:30 AM. The entries for 7:00 AM, 8:00 AM, and 9:00 AM were blank. The facility's Neurological Assessment policy and procedure, revision date 8/9/17, documented staff were to conduct neurological assessments every 15-minutes for an hour, every 30-minutes for two hours, every hour for five hours, and every 8 hours for 16 hours. On 1/11/18 at 1:50 PM, the DON stated the neurological assessment was not completed for Resident #22.	F 658			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690		2/16/18	

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F 690	<p>Continued From page 7</p> <p>resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents' urinary care needs were met. This was true for 1 of 3 sampled residents (#3)</p>	F 690	<p>1. One resident (#3) was impacted by the deficient practice. All staff in serviced regarding pericare as well as UTIs and E. Coli</p>		

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F 690	<p>Continued From page 8 for Urinary Tract Infections (UTIs). Resident #3 had the potential for harm when she developed recurrent UTIs. Findings include:</p> <p>Resident #3 was readmitted to the facility on 12/27/17 with diagnoses, including a history of UTIs, retention of urine, neuromuscular dysfunction of the bladder, urinary incontinence, malodorous urine, and cystitis.</p> <p>A quarterly MDS assessment, dated 10/18/17, documented Resident #3 was moderately cognitively impaired and was dependent on staff for all care needs.</p> <p>The Urinary Condition Care Plan, revised 11/24/17, documented Resident #3 experienced recurrent UTIs related to malodorous urine, and staff were to encourage fluids throughout the day, and provide cranberry tablets as ordered. The care plan documented Resident #3 was to receive assistance from staff after each incontinence episode to ensure "proper" pericare was provided.</p> <p>Resident #3 experienced multiple UTIs requiring antibiotic therapy and/or hospitalization:</p> <p>a. Urinalysis (UA) result from 10/20/17 documented Resident #3's urine appeared red and cloudy and contained blood, other proteins, nitrites, and bacteria.</p> <p>Resident #3's culture and sensitivity (C&S) result, dated 10/22/17, documented the presence of Escherichia Coli (E. coli).</p> <p>A 10/22/17 Physician's Order directed staff to</p>	F 690	<p>2. All residents that are incontinent of bowel/bladder have the potential to be impacted. All staff in serviced regarding pericare, UTI and E. Coli.</p> <p>3. Competency check sheets for pericare developed and administered to staff. All staff required to show competency. Any staff failing to meet competency will be retrained and tested for competency prior to working with residents.</p> <p>4. Competency check sheet will be utilized as audit tool. Instances of pericare administered by staff will be audited daily x5, weekly x4 and monthly x3. Any deficient care administered will be corrected on the spot. Results will be brought to QAPI committee. Audit will be conducted by DON or designee.</p> <p>5. 16 February 2018</p>		

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F 690	Continued From page 9 treat Resident #3's UTI with Augmentin 500-125 mg twice daily for ten days. b. A 12/17/17 Change of Condition Form documented Resident #3's urine was yellow with "some" odor. A 12/24/17 Nurse's Note documented Resident #3 experienced a change in condition of increased temperature and heart rate, and was transferred to the hospital. The Hospital Discharge Summary, dated 12/27/17, documented Resident #3's C&S results contained the presence of E. coli. On 1/12/18 at 8:50 AM, the ADON stated "clinically" most E. coli UTIs were due to a "lack of proper pericare." The ADON stated staff were to perform Resident #3's pericare minimally every two hours and he "hoped" this process was being completed appropriately. The ADON stated Resident #3 was on cranberry tablets and staff encouraged fluids to try and prevent UTIs. The ADON stated the facility also "encouraged excellent pericare."	F 690			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		2/16/18	

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F 761	<p>Continued From page 10</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based observation, interview, and record review, it was determined the facility failed to ensure a prescription medication label coincided with physician's orders. This was true for 1 of 5 residents (#14) sampled for medication review. This failure created the potential for harm when Resident #14's Lantus dosage and order on the pharmacy label was inconsistent with the physician's orders. Findings include: Resident #14 was admitted to the facility on 9/11/17 with multiple diagnoses including diabetes. Resident #14's Medication Review Report, dated 1/4/18, documented Lantus 15 units subcutaneously daily. Resident #14's Physician's Order, dated 1/5/18, documented to increase the Lantus to 17 units</p>	F 761	<ol style="list-style-type: none"> 1. One resident was impacted by the deficient practice. Medication was removed and replaced with medication that is accurately labeled. One hundred percent Medication cart audit conducted to ensure all medications are labeled appropriately. In service to LNs provided regarding correct labeling of medications in regard to a dosage change. 2. All residents receiving medication have the potential to be impacted. 3. In the event of a medication dosage change, the facility will ensure that the medication is accurately labeled. 4. Medication and Treatment audit utilized to audit for compliance. Audit conducted weekly x4 and monthly x3. Audit brought 		

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F 761	Continued From page 11 subcutaneously daily. On 1/10/18 at 12:45 PM, LPN #1 was following the EMAR (Electronic Medication Administration Record) to administer Lantus 17 units subcutaneously to Resident #14. The pharmacy label on the Lantus documented to administer 15 units subcutaneously. On 1/10/18 at 12:45 PM, LPN #1 stated the order was changed to administer 17 units to Resident #14. On 1/12/18 at 11:00 AM, the DON stated the pharmacy label did not coincide with the physician's order.	F 761	to QAPI committee. Audit conducted by DON or designee. 5. 16 February 2018		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		2/16/18	

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F 812	<p>Continued From page 12 standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to ensure measures were in place to prevent possible cross-contamination a) of dirty to clean areas in the kitchen; b) areas of the kitchen had cleanable surfaces; and c) prevent pests from entering the kitchen. This affected 14 of 15 (#'s 3-6, 8-11, 14, 16, 18, and 20-22) sampled residents and had the potential to affect all residents who dined in the facility. This failure created the potential for harm if residents contracted food-born illnesses or contagious diseases. Findings include:</p> <p>1. Kitchen Inspection:</p> <p>On 1/11/18 at 10:27 AM, the kitchen was observed with multiple uncleanable surfaces and pest entry points as follows:</p> <ul style="list-style-type: none"> * The floor contained three raised cracks, measuring approximately 4 inches in length, and multiple small holes in the floor. * The 20-foot in length white cabinet surfaces, were observed with flaking and missing paint, and a greasy substance covering their surfaces. The wood was exposed in areas; which created a porous surface for bacteria to reside. Approximately 15 feet of the cabinets were observed with a separation of varying degrees between the cabinets and the counter-top. * The counter-top was observed loose at a seam, which created a separation between counter-tops. 	F 812	<p>1. Fourteen residents were impacted by the deficient practice. Kitchen deep cleaned on 1/11/2018. Kitchen staff in serviced on proper clean-to-dirty side dish washing procedures. Deep cleaning schedule for kitchen staff revised to reflect duties by shift, instead of by day, and staff in serviced on updated responsibilities. Staff handling dishes trained on proper clean-to-dirty procedures. Staff handling dishes trained on proper clean-to-dirty procedures. Raised cracks and small holes in flooring were filled with proper sealant. Counter tops were reset on top of cabinets to repair separation between the two surfaces. Counter tops were reset on top of cabinets to remove separation between the two surfaces. Counter top seams were resealed to remove any separation. Floor boards were repaired or replaced to remove unsealed cracks in seams. Ceiling cracks were repaired and repainted. Exhaust fans seats were repaired/replaced to ensure proper fit. Kitchen windows were repaired/replaced to ensure they are being utilized in a proper and usable state. The kitchen was inspected and all missing paint points repainted. A deep clean was conducted according to schedule. Pest control contract will be utilized to conduct assessment of kitchen and mitigation steps recommended will be implemented.</p>		

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F 812	Continued From page 13 * Multiple white shelves in the pantry were observed with flaking and missing paint, and a greasy substance covered the surfaces. The wood was exposed in areas which created a porous surface for bacteria to reside. * The wall between the dishroom and the cooking area was observed with flaking and missing paint, and the floor boards contained 2 cracks in the seams approximately 6 inches in length. * Food debris and a layer of dirt was observed under the three-compartment sink. * Small dark pellets resembling mouse droppings, food particles, a grease film, and a dust layer were observed behind the oven and grill. The catch tray for the grill contained approximately a 2-centimeter-thick layer of dust, food particles, and grease. * The floor under the refrigerators contained food debris, dust, and grease spills. An unknown food fragment, approximately 1 inch by 2 inches, which appeared partially eaten on both sides, was observed under the refrigerators. * Baked on food debris and a brown film were observed on at least twenty pots and pans. * Multiple cracks were observed on the ceiling. The longest crack was approximately 20 feet in length, and where it intersected with the wall there was a sag point. * Two exhaust fans were observed without a proper seat. One of the fans had approximately a	F 812	2. All residents who receive oral nutrition have the potential to be impacted. 3.A Kitchen Environment audit tool has been developed. The audit will be conducted weekly x4 and monthly x3, results brought to QAPI committee. Audit conducted by Administrator or designee. 4.Results of the audit tool will be brought to the QAPI committee and reviewed for compliance. 5. 16 February 2018		

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F 812	Continued From page 14 2 inch by 4 inch opening where a pest could potentially enter the kitchen. * The windows in the kitchen were observed without a proper seal where a pest could potentially enter. Each of the surfaces described above presented potential areas for bacterial growth, pest entry, and subsequent spread of food-born illnesses. On 1/11/18 at 11:06 AM, the CDM stated the cabinets, walls, and shelves outlined above, were not cleanable. The CDM stated the food debris, food particles, and grease should be cleaned up. The CDM stated she was unsure if the floor, walls, and ceiling had water damage, however, the cracks were entry points for liquids. The CDM stated the window did not seal and this was a potential entry point for pests. 2. Dishware Washing: On 1/11/18 at 9:20 AM, Cook #1 was observed during the dishwashing process wearing gloves and a disposable apron. Cook #1 cleaned the soiled dishes, and sent them through the dishwasher. Cook #1 entered the clean dishware side of the area without taking her gloves and apron off, and without performing hand hygiene. The CDM in Training, present during the observation, stated this was not the correct procedure for cleaning dishware. She stated Cook #1 should have taken her gloves off, washed her hands, and removed her apron before touching the clean dishware.	F 812			
F 880	Infection Prevention & Control	F 880		2/16/18	

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F 880 SS=F	Continued From page 15 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of	F 880			

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F 880	<p>Continued From page 16</p> <p>infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 2 of 15 sampled residents (#6 and #16), when staff failed to perform effective hand hygiene during resident cares, and failed to practice universal</p>	F 880	<p>1. Two residents were impacted during cares and thirteen residents were impacted during meal service. In service on hand washing/ sanitizing provided to all staff.</p> <p>2. All residents have the potential to be</p>		

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F 880	<p>Continued From page 17</p> <p>precautions for 13 random residents observed during meal service in the dining room. These failures created the potential for harm if infections spread among residents. Findings include:</p> <p>1. Hand hygiene observations during cares and interviews:</p> <p>On 1/8/18 at 4:38 PM, CNA #1 and CNA #6 were observed assisting Resident #16 with pericare, the CNAs took turns from their respective sides. CNA #6 removed her gloves after completing pericare, entered Resident #16's bathroom, applied soap to her hands, ran her hands under the water for 5 seconds before turning off the water, and dried her hands. CNA #6 left the room to acquire a Hoyer lift and CNA #2 replaced CNA #6 in Resident #16's room.</p> <p>On 1/8/18 at 5:00 PM, CNA #1 and CNA #2 were observed assisting Resident #16 out of bed with a mechanical lift and stopped due to Resident #16's pants were saturated again. The CNAs laid Resident #16 down to perform pericare again, each from their respective sides. CNA #1 and CNA #2 donned gloves and assisted Resident #16 with pericare. CNA #1 removed her soiled gloves and placed new gloves on her hands, without first performing hand hygiene, and assisted Resident #16 put on undergarments. CNA #2 did not remove her soiled gloves or perform hand hygiene until after the CNAs had clothed Resident #16. CNA #2 entered Resident #16's bathroom, applied soap to her hands, ran her hands under the water for 7 seconds before turning off the water, and dried her hands. During the observation, CNA #1 was observed coughing on to her wrist, and continued with cares without</p>	F 880	<p>impacted by the deficient practice.</p> <p>3. Competency check sheet related to hand hygiene/ hand sanitizing developed and all staff will be required to show competency. Hand hygiene importance and/or proper execution added as topic for all-staff meeting for remainder of the year. Hand hygiene audit tool developed and utilized during staff competency checks on hire and at least annually thereafter.</p> <p>4. Hand hygiene audit will be conducted daily x5, weekly x4, monthly x3. Any deficient care administered will be corrected on the spot. Results will be brought to QAPI committee. Audits conducted by Administrator or designee.</p> <p>5. 16 February 2018</p>		

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F 880	<p>Continued From page 18</p> <p>hand hygiene or changing gloves. CNA #1 was observed coughing again and not covering her mouth. CNA #1 was facing Resident #16.</p> <p>On 1/10/18 at 10:58 AM, CNA #4 and CNA #3 were observed assisting Resident #6 with pericare. CNA #3 and CNA #4 donned gloves and assisted Resident #16 with pericare, the CNAs took turns from their respective sides. CNA #4 removed her gloves after completing pericare, entered Resident #6's bathroom, applied soap to her hands, ran her hands under the water for 8 seconds before turning off the water, and dried her hands. CNA #3 did not remove her soiled gloves or perform hand hygiene until the CNAs clothed Resident #6. CNA #3 removed her gloves, exited the room, utilized hand sanitizer in the hall, where she rubbed the palms of her hands together three times, and then wrung her hands in the air. CNA #3 then went to a sink in the small dining room, and applied soap to her hands, ran her hands under the water for 4 seconds before turning off the water, and dried her hands.</p> <p>On 1/12/18 at 8:50 AM, the ADON stated the "proper" process to complete pericare was as follows:</p> <ul style="list-style-type: none"> * wash hands and put gloves on, * perform pericare, wiping from front to back, * remove gloves after pericare, and * then perform hand hygiene and reapply clean gloves. <p>The ADON stated staff were encouraged to utilize soap and water when performing hand hygiene. The ADON stated staff were to wash</p>	F 880			

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F 880	<p>Continued From page 19</p> <p>their hands for 20 seconds or more when utilizing soap and water. The ADON stated if staff utilized hand sanitizer they should rub all the surfaces of their hands and continue rubbing until their hand were dry.</p> <p>The ADON stated staff were to perform hand hygiene when transitioning from dirty to clean processes. The ADON stated the observations described above were not appropriate hand hygiene practices. The ADON stated the facility was "currently working on" their infection control program to ensure hand hygiene practices were performed appropriately and he would increase audits.</p> <p>2. Hand hygiene observations during dining:</p> <p>On 1/8/18 from 5:35 PM to 5:56 PM, CNA #1, CNA #5, the Activities Director and the DON were observed assisting 10 residents in the dining room with delivering trays, cutting up food, inserting straws into drinks, filling up drinks, and assisting residents with eating without consistent hand hygiene practices. CNA #5 was observed grasping 3 residents' cups by the rim with no hand hygiene practice performed. The Activities Director was observed touching 3 residents' backs, and then inserting straws into other residents' drinks. The Activities Director performed hand hygiene periodically throughout the observations, which lasted for 3 - 8 seconds. CNA #1 was observed assisting two residents to eat without performing hand hygiene between moving from resident to resident. The DON was observed delivering trays and assisted 2 residents with setting up their meals to eat. The DON performed hand hygiene periodically</p>	F 880			

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NAME OF PROVIDER OR SUPPLIER OAK CREEK REHABILITATION CENTER OF KIMBERLY			STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 20 throughout the observations which lasted for 3 seconds. On 1/10/18 from 5:43 PM to 6:04 PM, Registered Nurse [RN] #1 was observed delivering trays, assisting 3 residents with tray set up needs, and then assisted a resident with eating her meal, all without performing hand hygiene. On 1/12/18 at 8:50 AM, the ADON stated staff were encouraged to utilize soap and water when performing hand hygiene. The ADON stated staff were to wash their hands for 20 seconds or more when utilizing soap and water. The ADON stated if staff utilized hand sanitizer they should rub all the surfaces of their hands and continue rubbing until their hand were dry. The ADON stated staff were to perform hand hygiene when transitioning from dirty to clean processes. The ADON stated the observations described above were not appropriate hand hygiene practices.	F 880			
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview the facility failed ensure the kitchen was free from pests. This affected 14 of 15 (#'s 3-6, 8-11, 14, 16, 18, and 20-22) sampled residents and all residents who dined in the facility. This had the potential for psychosocial from potential infestation of pests. Findings include: On 1/11/18 at 10:27 AM, the kitchen was	F 925	1. Fourteen residents were impacted by the deficient practice. Kitchen deep cleaned on 1/11/2018. Pest control contractor was contacted and visit conducted. Raised cracks and small holes in flooring filled with proper sealant. Counter tops reset on top of cabinets to remove separation between the two surfaces. Counter top seems resealed to	2/16/18	

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NAME OF PROVIDER OR SUPPLIER OAK CREEK REHABILITATION CENTER OF KIMBERLY			STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
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F 925	<p>Continued From page 21</p> <p>observed with multiple pest entry points as follows:</p> <ul style="list-style-type: none"> * The floor boards in the dishroom contained 2 cracks in the seams, approximately 6 inches in length. * Small dark pellets resembling mouse droppings, food particles, a grease film, and a dust layer were observed behind the oven and grill. * The floor under the refrigerators contained an unknown food fragment, approximately 1 inch by 2 inch, which appeared partially eaten on both sides. * Two exhaust fans were observed without a proper seat. One of the fans had approximately a 2 inch by 4 inch opening where pests could potentially enter the kitchen. * The windows in the kitchen were observed without a proper seal where pests could potentially enter. <p>Each of the areas described above presented potential areas for pests to enter and food for the pest to eat.</p> <p>On 1/11/18 at 11:06 AM, the CDM stated the food debris, food particles, were potential food for pests. The CDM stated the window did not seal and this was a potential entry point for pests.</p> <p>On 1/12/18 at 1:10 PM, the Maintenance Director stated a routine visit had been conducted by their pest control company recently, and stated he</p>	F 925	<p>remove any separation. Floor boards repaired or replaced to remove unsealed cracks in seems. Ceiling cracks repaired and repainted. Exhaust fans seats repaired/replaced to ensure proper fit. Kitchen windows repaired/replaced to provide seal to outside. Deep clean conducted according to schedule.</p> <p>2. All residents have the potential to be impacted.</p> <p>3. Pest control contract utilized to conduct assessment of kitchen and mitigation steps needed will be implements. A Kitchen Environment audit tool was developed. The audit will be conducted weekly x4, and monthly x3, results brought to QAPI committee. Audit conducted by Administrator or designee.</p> <p>4. The results of the audit tool will be brought to QAPI committee and reviewed for compliance.</p> <p>5. 16 February 2018</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER OAK CREEK REHABILITATION CENTER OF KIMBERLY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
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F 925	Continued From page 22 would schedule a spot visit for the following week.	F 925		